HEALTH BENEFITS GUIDE 2003

Commonwealth of Virginia Health Benefits Program
Department of Human Resource Management

Plans Effective July 1, 2003

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INTRODUCTION

This Guide provides a summary of the health benefit plans offered for July 1, 2003 under the Commonwealth of Virginia Health Benefits Program. You may choose coverage in the new COVA Care basic plan, and by paying extra premium, you may add one or more of three benefit options. The COVA Care basic plan and optional benefits are described in the Guide beginning on page 5. If you live in the Northern Virginia area you may also choose coverage in the Kaiser Permanente HMO. The Kaiser Permanente plan is described beginning on page 17.

The Guide also supplies you with practical information about how to enroll in a plan, change your type of membership, and access a wide range of health benefits information on the DHRM Web site at **www.dhrm.state.va.us.**

Plan Monthly Premiums

Monthly premiums for the COVA Care and Kaiser Permanente plans may be found on the DHRM Web site at **www.dhrm.state.va.us/hbenefits.htm**. The rates are also published in the March 2003 edition of the Spotlight newsletter, and in the April 2003 notification mailed to non-Medicare retirees and Extended Coverage participants.

SPECIAL PROGRAMS

All participants in the Commonwealth of Virginia Health Benefits Program have access to the following wellness and preventive care programs.

CommonHealth

The CommonHealth wellness program is offered to state employees through participating state agencies. The program is designed to make a positive difference in the health of the individual employee by integrating health awareness into the workplace. CommonHealth features a variety of medical screenings including cholesterol and blood pressure; fitness classes and challenges; health education programs and other activities. For more information, visit the new CommonHealth Web site at **www.chp-online.com/commonhealth**.

Baby Benefits℠ Through CommonHealth

Available at no cost to employees, spouses or dependents through CommonHealth, the Baby Benefits prenatal program helps to ensure healthy pregnancies and to reduce the chance of premature deliveries. A consultant (a nurse or health educator) works with the mother and her doctor during pregnancy. As soon as pregnancy is confirmed, employees, spouses, or dependents may sign up for Baby Benefits by calling **1-800-828-5891**.

ENROLLMENT, PLAN OR MEMBERSHIP CHANGES

1. Reasons For Choosing A Plan Or Type Of Membership

- New employee enrolling for the first time in a plan and membership category
- Making a plan and/or membership change during Open Enrollment
- Making a membership change outside of Open Enrollment due to a qualifying mid-year event (life event). Examples of these events include marriage, birth of a child and a child who reaches the plan age limit and is no longer eligible. There are limited times when a plan change may be made based on a qualifying mid-year event.

For additional information, and a list of qualifying mid-year events, see Enrolling and Making Changes on the DHRM Web site at **www.dhrm.state.va.us/hbenefit.htm** or request an Eligibility Rules Sheet from your Benefits Administrator.

2. Types Of Membership

Choose from three levels of membership:

- **Employee Single** – *To cover yourself only*
- **Employee Plus One** – *To cover yourself and one eligible dependent (spouse or child)*
- **Family** – *To cover yourself and two or more eligible dependents*

For a list of those individuals eligible to enroll under your plan, see the Eligibility Rules at **www.dhrm.state.va.us/hbenefit.htm** or request an Eligibility Rules Sheet from your Benefits Administrator.

3. How To Enroll In A Plan Or Change Membership

Use EmployeeDirect On The Web Or Submit An Enrollment Form

Go to the Department of Human Resource Management's Web site at **http://www.dhrm.state.va.us/hbenefit.htm**. Choose the EmployeeDirect or the Forms tab. The EmployeeDirect health benefits enrollment and information system is the fastest and easiest way to enroll in or change your health and related benefits. However, you may print an Enrollment form, complete it and submit it to your agency's Benefits Administrator. If you do not have access to the Web, see your Benefits Administrator for a form.

Important: You must use EmployeeDirect or submit an Enrollment Form to your Benefits Administrator within 31 days of the event. Most changes are effective the first of the month following receipt of the completed form or submission in EmployeeDirect.

Enrollment Provision Under HIPAA: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Women's Health And Cancer Rights: In the case of a participant who is receiving benefits under the state's health benefits plan in connection with a mastectomy, and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications during all stages of the mastectomy

Important Reminders

How To Maximize Your Health Benefits

Here are some tips on getting the most from your health benefits:

- **Submit notice within 31 days of a qualifying mid-year event.** When you experience an event during the year which allows a change in membership or plan, following the 31-day rule ensures that the change occurs. Employees may give notice on EmployeeDirect or submit a completed Enrollment form. Remember that most changes are effective the first of the month after notice is received.
- **Add eligible family members to your coverage.** Employees have another 31 days of a qualifying mid-year event to add a family member, such as a spouse or newborn baby, to the coverage. Remember that failure to meet the deadline will mean no coverage for the family member.
- **Remove ineligible family members from your coverage.** The penalty for carrying ineligible members is removal from the Health Benefits Program for up to three years. Dependents who are never eligible: children who have reached the age limit of 23 (by the end of a calendar year unless they are certified as disabled), divorced spouses and children who are self-supporting or married (they lose eligibility at the end of the month in which the event occurs).

HEALTH BENEFITS RESOURCES ONLINE

Visit the DHRM Web site at **www.dhrm.state.va.us/hbenefit.htm** to:

- *Link to EmployeeDirect to…*
  - Review your Benefits Profile
  - Make Open Enrollment changes
  - Make changes due to a qualifying mid-year event
  - Update your address or other personal information
- *Link to the Active Employee page to…*
  - Find statewide and regional plan information and forms
  - Look up eligibility information
  - Download this Health Benefits Selection Guide, plus Member Handbooks, Enrollment Forms, and Monthly Rates
  - Link to each plan's Web site for Commonwealth of Virginia employees
- *Research specific information including…*
  - Appeals Process
  - Newsletters and Annual Reports
  - Quality Report Cards —The Quality Report Cards allow you to evaluate the plans in these areas: plan accreditation by the National Committee for Quality Assurance (NCQA), number of people enrolled in the plan, effectiveness of care, PCP availability and access to care, network provider criteria, physician turnover in the plan network, and overall member satisfaction with the plan.

HOW TO CONTACT THE PLANS

	Call Or Visit The Web Site	
COVA Care – Statewide Plan	**Medical, Dental and Prescription Drug:** Anthem Blue Cross and Blue Shield **(804) 355-8506** in Richmond **1-800-552-2682** outside Richmond Web: **www.anthem.com**	**Mental Health And Substance Abuse:** Magellan Behavioral Health **1-800-775-5138** Web: **www.magellanassist.com**
Kaiser Permanente – Regional HMO	**Medical, Prescription Drug and Mental Health:** Kaiser Foundation Health Plan, Inc. **(301) 468-6000** in Washington D.C. area **1-800-777-7902** outside Washington D.C. Web: **www.kp.org/ehealth/mida/commonwealthofvirginia**	**Dental:** **1-800-445-9090**

COVA CARE — STATEWIDE PLAN

SERVICE AREA

COVA Care is available wherever you or your enrolled dependents work or live.

HOW BENEFITS ARE ADMINISTERED

Your benefits are administered on a calendar year basis, which begins January 1 and ends on December 31.

PROVIDER NETWORKS FOR MEDICAL CARE

You have coverage within the Anthem network and the BlueCard® PPO network. Except in an emergency, you do not have coverage outside these networks, *unless* you have purchased the Out-of-Network Benefits Option.

Anthem Network

COVA Care covers medical care provided by hospitals, primary care physicians and specialists. To see a primary care physician, simply visit an Anthem network physician who is a general or family practitioner, internist or pediatrician. Your plan also covers care provided by any other specialist in the Anthem network. Referrals are never needed to visit a network specialist. However, higher copayments apply for specialist visits.

The most current directory of Anthem providers is on the Web at **www.anthem.com** under Members and Consumers, Virginia. Select the Commonwealth of Virginia and The Local Choice provider directory link. You may also contact Anthem Member Services at **1-800-552-2682** or see your agency Benefits Administrator for a printed directory.

BlueCard® Networks

BlueCard PPO For Care Within The United States

If you need medical care outside the Anthem network and within the United States, you will receive the highest level of benefits when you receive care from a BlueCard PPO provider. Through the BlueCard PPO program, your Anthem Blue Cross and Blue Shield ID card is accepted by physicians and hospitals throughout the country who participate with another Blue Cross Blue Shield company. These providers accept your copayment or coinsurance at the time of service instead of requiring full payment. They file claims directly to their local Blue Cross Blue Shield company for you, and have agreed to accept the allowable charge established by the local company as payment in full.

To locate a BlueCard PPO physician or hospital call **1-800-810-BLUE (2583)**. Or use the BlueCard Doctor and Hospital Finder on the Web at **www.bcbs.com**. Providers can also tell you if they participate in BlueCard PPO when you call to make an appointment.

Simply present your Anthem ID card when you receive care. The PPO suitcase logo at the top of your card tells the physician or hospital that your COVA Care plan includes the BlueCard PPO program.

BlueCard Worldwide® For Care Outside The United States

If you live or travel outside the United States, you will receive the highest level of benefits when your care is coordinated through the BlueCard Worldwide Service Center. The BlueCard Worldwide program enables you to receive inpatient and outpatient hospital care and physician services when you are outside the United States.

Follow These Steps Before You Travel…

1. Obtain a list of BlueCard Worldwide hospitals located where you will be traveling or staying. You may obtain this information on the Web at **www.bluecares.com/healthtravel/worldwide.html**. Or you may call **1-800-810-BLUE (2583)** for a list.
2. Be sure to carry your Anthem medical ID card with you and present it anytime you receive medical care.

If You Need Care Once You Arrive At Your Destination, Follow These Simple Steps…

Inpatient Hospital Care

Non-emergency:

1. Call the BlueCard Worldwide Service center at **1-800-810-BLUE (2583)**. (You can access this number outside the U.S. by using an AT&T Direct® Access Number.) The Service Center will facilitate hospitalization at a BlueCard Worldwide hospital. It is important that you call the Service Center in order to obtain cash-less access for inpatient care. The hospital will submit your claim for you. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.
2. Call Anthem at **1-800-242-7277** for hospital admission review.

Emergency:

Bypass the above steps. Go to the nearest hospital. Call the BlueCard Worldwide Service Center at **1-800-810-BLUE (2583)** or collect at **1-804-673-1177** if you are admitted. A family member or friend can make this call for you.

Outpatient Care

1. Call the BlueCard Worldwide Service center at **1-800-810-BLUE (2583)**. The Service Center will make an appointment with a doctor for you or will direct you to a hospital.

Present your Anthem medical ID card. You will need to pay for your care and then submit a claim using the International Claim Form. Contact the Service Center for the form, or you may download the form on the Web at **www.bluecares.com/healthtravel/worldwide.html**.

What Are The Advantages Of The BlueCard PPO And BlueCard Worldwide Programs?

- 85% of all hospitals and physicians in the U.S. participate in the BlueCard PPO program. There are 560,000 BlueCard PPO physicians and 5,200 hospital facilities.
- The BlueCard PPO program includes 43 Blue Cross and Blue Shield plans with networks in every state.
- The BlueCard Worldwide program includes 954 hospitals in 122 countries.

Except in an emergency, the COVA Care rules for hospital admission review and prior authorization for certain medical services apply under the BlueCard PPO and BlueCard Worldwide programs.

THREE-TIER DRUG PROGRAM

Your Three-Tier Drug Copayments

Prescription drugs are divided into three tiers or categories, and you pay the appropriate prescription copayment by tier. In general, the first tier covers generic drugs which are usually the least expensive. The second tier is lower cost brand name drugs. The third tier is higher cost brand name drugs and may include newly introduced drugs.

To determine in which tier your prescription drug falls, go to **www.anthem.com**. Select Members and Consumers, then choose Virginia. On the home page select the link to Commonwealth of Virginia and The Local Choice Members. Then select the Prescription Drug Program link. You may also contact Anthem Member Services for assistance.

	First Tier Copayment *Typically Generic Drugs*	Second Tier Copayment *Low to Mid-Cost Brand Name Drugs*	Third Tier Copayment *Typically Higher Cost Brand Name Drugs*
Participating Retail Pharmacy: Per 34-day supply*	$15	$20	$35
Home Delivery Pharmacy: Per 90-day supply	$30	$40	$70

**You may purchase up to a 68-day supply for two copayments, or up to a 102-day supply for three copayments.*

Retail Pharmacy

This is a mandatory generic drug program. If a generic equivalent exists for a brand name drug, you have two choices. You may request the generic and pay only the copayment. Or you or your physician may request a brand name drug and you will be responsible for the following:

- At a participating pharmacy you will be responsible for the applicable copayment plus the difference between the allowable charge for the generic equivalent and the allowable charge for the brand name drug.
- At a non-participating pharmacy you pay the total price for the drug and then file a Prescription Drug Direct Reimbursement Claim Form. Reimbursement is limited to the allowable charge for the generic drug minus your copayment.

To obtain prescriptions at a participating retail pharmacy simply:

1. Present your Anthem identification card to your pharmacist.
2. Pay the appropriate copayment. The pharmacist will tell you the amount of your copayment. You pay one copayment per 34-day supply. You may purchase up to a 68-day supply for two copayments, and up to a 102-day supply for three copayments.
3. If you request a brand name drug when a generic is available, you pay the appropriate copayment plus the difference between the generic and the brand name allowable charge.

Note: Some drugs require Prior Authorization before they are dispensed. See *Approval of Care At A Glance*, page 15.

Home Delivery Pharmacy

This is a convenient, cost-effective way to obtain up to a 90-day supply of medications you take routinely (such as medication for high blood pressure or high cholesterol). You pay only two copayments for a 90-day supply, and your medications are delivered directly to your home. You will receive a Home Delivery Pharmacy packet with your medical identification card when you enroll in the plan, or contact Anthem Member Services for a packet.

The Home Delivery Pharmacy also is a mandatory generic drug program. If a generic exists for a brand name drug, you may request the generic and pay only the copayment. Or you or your physician may request a brand name and you will pay the applicable copayment plus the difference between the allowable charge for the generic and the brand name drug.

Choose one of four ways to obtain prescriptions from the MedcoHealth Home delivery pharmacy:

1. **Online**: Go to **www.medcohealth.com**. Have your medical ID number and prescription number on hand. You will need to register the first time you place an order online. For future refills you will need your 12-digit prescription number.
2. **Telephone:** This is available for refills once you are already registered into the system. Call **1-800-4REFILL (1-800-473-3455)** to use the automated refill system.
3. **Fax:** Have your doctor fill out an EasyRx℠ fax form and follow the instructions for sending it to us. The fax form and complete instructions for your doctor are available online at **www.medcohealth.com**. Important: Only your doctor may fax the completed form to us.
4. **Mail:** Mail in a prescription from you doctor and the Home Delivery Order Form. The form is available online at **www.medcohealth.com**, from your Benefits Administrator, or from Anthem Member Services.

DENTAL BENEFITS

Your plan includes basic dental benefits for services such as oral examinations, cleanings, x-rays, fillings, and root canals, as shown below.

To reduce your out-of-pocket expense, choose an Anthem Blue Cross and Blue Shield network dentist shown in the Commonwealth of Virginia and The Local Choice Provider Directory. View the Provider Directory on the Web at **www.anthem.com**. On the home page, choose Members and Consumers, then select Virginia. Click on the Commonwealth of Virginia and The Local Choice Provider Directory. If you go to a non-network dentist, you will pay more.

You may purchase the Expanded Dental Benefits option if you want to add coverage for complex restorative services such as crowns and dentures, and orthodontic services. See page 13 for more information about this option.

Plan Pays $1,200 Maximum Per Member Each Year		In-Network You Pay
Diagnostic And Preventive	Twice-a-year visits to the dentist for oral examinations, x-rays, and cleanings	$0
Primary	Fillings, oral surgery, periodontal services, scaling, repair of dentures, root canals and other endodontic services, and recementing of existing crowns and bridges	20% coinsurance
Out-Of-Network Care	For services by a non-network dentist, you pay the applicable coinsurance plus any amounts above the allowable charge. Claims payments are made directly to the member, unless the member assigns benefits to the provider.	

OUT-OF-POCKET EXPENSE LIMIT

Once you have met your calendar year out-of-pocket expense limit, COVA Care covers 100% of the allowable charge for many services.

If You Have NOT Purchased The Out-of-Network Option

What Counts Toward Your Out-of-Pocket Expense Limit

- Deductible, copayments and coinsurance for covered services from providers and facilities in your Anthem, BlueCard PPO, or Magellan Behavioral Health networks

What Does Not Count Toward Your Out-of-Pocket Expense Limit

- Deductible, copayments and coinsurance for services from providers and facilities NOT in your Anthem, BlueCard PPO, or Magellan Behavioral Health networks
- Amounts above the allowable charge
- Amounts above the health plan limits
- Copayments and coinsurance for outpatient prescription drugs, routine dental services, and the optional routine vision and hearing benefits
- Expenses for services or supplies not covered by the plan

If You HAVE Purchased The Out-of-Network Option

What Counts Toward Your Out-of-Pocket Expense Limit

- Deductible, copayments and coinsurance for covered services from providers and facilities in your Anthem, BlueCard PPO, or Magellan Behavioral Health networks, and also from providers and facilities NOT in the networks

What Does Not Count Toward Your Out-of-Pocket Expense Limit

- The plan's 25% payment reduction for covered services from providers and facilities NOT in your Anthem, BlueCard PPO, or Magellan Behavioral Health networks
- Amounts above the allowable charge
- Amounts above the health plan limits
- Copayments and coinsurance for outpatient prescription drugs, routine dental services, and the optional routine vision and hearing aid benefits
- Expenses for services or supplies not covered by the plan

SUMMARY OF BENEFITS — COVA CARE

	For Covered Services
Annual Deductible	$200 per person; $400 per family *Applies to certain services requiring coinsurance, including diagnostic laboratory, tests, shots, x-rays, ambulance travel and durable medical equipment*
Out-of-Pocket Expense Limit	$1,500 per member $3,000 per family *Annual deductible, copayments, and coinsurance for in-network medical and mental health services count toward the limit. Prescription drug, dental, vision and hearing copayments and coinsurance do not apply.*

Covered Services (in alphabetical order)	You Pay In-Network Copayment Per Visit	You Pay In-Network Coinsurance
Dental basic services *(Plan pays up to $1,200 per member per year)*		
• *Diagnostic and preventive (oral exam, cleanings, etc.)*	$0	0%
• *Primary (fillings, periodontal, root canals, etc.)*	$0	20% **no** deductible
Diabetic supplies and equipment	$0	20% after deductible
Diabetic education	$0	0%
Diagnostic laboratory, tests, shots and x-rays	$0	10% after deductible
Doctor's visits		
Outpatient		
• *Primary care physicians*	$25	0%
• *Specialists*	$35	0%
Inpatient		
• *Primary care physicians*	$0	0%
• *Specialists*	$0	0%
Emergency room visits		
• *Facility services*	$100	0%
• *Professional provider services:*		
• *Primary care physicians*	$25	0%
• *Specialists*	$35	0%
• *Diagnostic laboratory, tests, shots and x-rays*	$0	10% after deductible
Hospital services		
Inpatient facility	$300 per stay	0%
Outpatient facility	$100	0%

Covered Services (in alphabetical order)	You Pay In-Network Copayment Per Visit	You Pay In-Network Coinsurance
Maternity		
Prenatal, delivery and postnatal care (There is only one copayment if the provider submits one bill for all the mother's routine pre- and postnatal care and the delivery of the child)	$35	0%
Hospital services for delivery (delivery room, anesthesia, nursing care for newborn)	$300 per stay	0%
Outpatient diagnostic tests	$0	10% after deductible
Medical equipment, appliances and supplies	$0	20% after deductible
Mental health and substance abuse treatment *(All services must be approved in advance)*		
Inpatient facility and partial day program	$300 per stay	0%
Outpatient facility	$100	0%
Outpatient professional services	$35	0%
Prescription drugs		
Retail pharmacy – per 34-day supply		
• *Tier 1*	$15	0%
• *Tier 2*	$20	0%
• *Tier 3*	$35	0%
Home delivery service – per 90-day supply		
• *Tier 1*	$30	0%
• *Tier 2*	$40	0%
• *Tier 3*	$70	0%
Spinal manipulations and other manual medical interventions *(Plan pays up to $500 per member per year)*		
• *Primary care physicians*	$25	0%
• *Specialists*	$35	0%
Therapy services		
Chemotherapy, Infusion, Radiation, and Respiratory therapy		
• *Outpatient facility services*	$0	0%
• *Professional provider services*	$0	0%
Occupational, Physical, and Speech therapy		
• *Outpatient facility services*	$35	0%
• *Professional provider services:*		
• *Primary care physicians*	$25	0%
• *Specialists*	$35	0%

Covered Services (in alphabetical order)	You Pay In-Network Copayment Per Visit	You Pay In-Network Coinsurance
Wellness And Preventive Services		
Well child care (through age 6)		
• *Office visits:*		
• *Primary care physicians*	$25	0%
• *Specialists*	$35	0%
• *Immunizations*	$0	0%
• *Screening tests*	$0	10% **no** deductible
Routine wellness care (age 7 and older)		
• *Annual check-up visit*		
• *Primary care physicians*	$25	0%
• *Specialists*	$35	0%
• *Routine laboratory, tests, shots, and x-rays (Plan pays 90% coinsurance up to $200 per member per year)*	$0	10% **no** deductible
Preventive care (one of each per year)		
• *Annual gynecological exam*		
• *Primary care physicians*	$25	0%
• *Specialists*	$35	0%
• *Prostate exam (age 40 and older)*		
• *Primary care physicians*	$25	0%
• *Specialists*	$35	0%
• *Pap test*	$0	10% **no** deductible
• *Mammography screening (age 35 and older)*	$0	10% **no** deductible
• *Prostate specific antigen test (age 40 and older)*	$0	10% **no** deductible
• *Colorectal cancer screening (age 40 and older)*	$0	10% **no** deductible

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT

Your mental health and substance abuse benefits under the COVA Care health plan are administered by Magellan Behavioral Health. To access these benefits or ask questions relating to the plan, call Magellan at **1-800-775-5138**.

You must call Magellan for pre-authorization before receiving care. Treatment must be medically necessary. Magellan will refer you to the appropriate mental health provider and review your treatment plan. If you receive care without prior approval, Magellan will pay the claim if the services were medically necessary and you sought care from a provider who participates in the Magellan network. However, if the provider does not participate with Magellan, the claim will not be paid. If you add the Out-of-Network option to your COVA Care plan, Magellan will pay your medically necessary claims, but at a lower level of benefits. Magellan's payment will be reduced by 25 percent.

COVA CARE OPTIONAL BENEFITS

These benefits may be purchased for additional premium.

1. Out-Of-Network Benefit

This option allows you to receive covered services at a reduced level from non-network providers—that is, providers that are not in the Anthem, BlueCard PPO, or Magellan Behavioral Health networks. The plan payment for covered services is reduced by 25%. You are responsible for any applicable deductible, copayment or coinsurance. You also pay any balance above the allowable charge. Claims payments are made directly to the member when services are received from a non-network provider.

Example Of How Out-of-Network Option Works For Diagnostic Tests:

Plan Or Option	In-Network	Out-Of-Network
COVA Care – Basic Plan	*You pay…* 10% coinsurance after deductible	No coverage
COVA Care With Out-Of-Network Option	*You pay…* 10% coinsurance after deductible	*You pay…* 10% coinsurance plus a 25% reduction after deductible. You also pay any amount the provider charges over the allowable charge

2. Expanded Dental Benefit

This option allows you to add Complex Restorative and Orthodontic benefits to your basic dental benefits. The maximum the plan pays each calendar year for the basic dental and complex restorative is $300 more than under the COVA Care basic plan.

Plan Pays $1,500 Maximum Per Member Each Year (For Basic And Expanded Dental)		In-Network You Pay
Complex Restorative	Inlays, onlays, crowns, dentures, bridges, relining dentures for a better fit, and implants	50% coinsurance, no deductible
Orthodontic Services (Plan pays $1,200 maximum per lifetime per enrolled member)	Services to correct a handicapping malocclusion (a severe deviation from the normal range of positioning of the teeth), tooth guidance and harmful habit appliances, interceptive treatment, surgical exposure of unerupted teeth when performed for orthodontic purposes, orthodontic x-rays, and orthodontic evaluations when no treatment is initiated **There is a 12-month waiting period to receive coverage for orthodontic services. Credit toward this waiting period will be given if you had orthodontic benefits under previous coverage, and that coverage ends the day before this coverage begins. In addition, orthodontic benefits paid under the previous coverage will count against the $1,200 lifetime maximum.**	50% coinsurance, no deductible
Out-Of-Network Care	For services by a non-network dentist, you pay the applicable coinsurance plus any amounts above the allowable charge. Claims payments are made directly to the member, unless the member assigns benefits to the provider.	

To reduce your out-of-pocket expense, choose an Anthem Blue Cross and Blue Shield network dentist shown in the Commonwealth of Virginia and The Local Choice Provider Directory. View the Provider Directory on the Web at **www.anthem.com**. If you go to a non-network dentist, you may pay more of the bill.

3. Vision, Hearing and Expanded Dental Benefit

This option provides you with the following Routine Vision and Hearing benefits, *plus* the Expanded Dental benefits described on the previous page.

Routine Vision Benefits

Covered Services (Once Every 24 Months)		In-Network You Pay
Routine Eye Examination		$35 per specialist visit, no deductible
Covered Services (Once Every 24 Months)		**Plan Pays Up To**
Eyeglass Frames		$75
Lenses	• One pair of eyeglass lenses:	
	Single lenses	$50
	Bifocal lenses	$75
	Trifocal lenses	$100
	OR	
	• Contact lenses (regardless of type)	$100

To reduce your out-of-pocket expense, choose an Anthem Blue Cross and Blue Shield optician, optometrist or ophthalmologist. View the Provider Directory on the Web at **www.anthem.com**. If you go to a non-network provider for your routine eye examination, in addition to the $35 copayment, you also may be billed for the difference between Anthem's allowable charge and the provider's charge.

You are responsible for paying any costs above the amounts listed for eyeglass frames and lenses. Providers may require payment from you for the difference between this fixed amount and their charges. The provider may choose to file the claim for you, or you may use the standard Anthem claim form to file your claim.

If you need medical treatment for your eyes, consult your physician or a network eye specialist.

Routine Hearing Benefits

Covered Services (Once Every 48 Months)	In-Network You Pay
Routine hearing examination from network hearing provider	$35 per specialist visit, no deductible
	Plan Pays Up To
Hearing aid(s) and other related hearing aid services such as selection and fitting	$1,200 per member

If you receive services from a non-network hearing provider, in addition to the $35 copayment, you also may be billed for the difference between Anthem's allowable charge and the provider's charge.

Expanded Dental Benefits

See Page 13.

OPTIONAL BENEFITS COMBINATIONS

The three benefit options — Out-Of-Network, Expanded Dental, and Vision, Hearing and Expanded Dental — may be added to your standard COVA Care plan as follows:

1. COVA Care with Out-Of-Network Benefit
2. COVA Care with Expanded Dental Benefits
3. COVA Care with Routine Vision, Hearing and Expanded Dental Benefits
4. COVA Care with Out-Of-Network Benefit **and** Expanded Dental Benefits
5. COVA Care with Out-Of-Network Benefit **and** Routine Vision, Hearing and Expanded Dental Benefits

APPROVAL OF CARE AT A GLANCE

Type of Service	Before You Receive Care
Emergency Care (*Such as high fever, vomiting, sprains, or broken bones*)	You must obtain Hospital Admission Review if admitted.
Inpatient Hospital Care (Medical/Surgical)	All hospital admissions must be coordinated by your physician and reviewed and approved in advance by Anthem. Before a hospital admission, you, your physician, a family member, or friend must call Anthem Blue Cross and Blue Shield: In Richmond: **(804) 359-7277** Outside Richmond: **1-800-242-7277** However, if your physician does not make the call, it is your responsibility to make the call. The call must be made within 48 hours of an admission for a life-threatening emergency.
Outpatient Services Which Require Medical Review	To determine if a service requires medical review, contact your physician or Anthem Member Services. This process is also called pre-authorization. You could be responsible for the full cost of a service that requires medical review if it is not authorized in advance.
Prescription Drugs Which Require Prior Authorization	Your physician, pharmacist, or Anthem Member Services can tell you if a drug requires prior authorization. Your physician may request approval for drugs that require prior authorization on your behalf. To view a list of covered drugs and see if prior authorization is required, go to the Web at **www.anthem.com**.
Mental Health Care Or Substance Abuse Treatment	Call Magellan Behavioral Health at **1-800-775-5138** for pre-authorization of care. Call within 48 hours after an emergency admission.

SPECIAL PROGRAMS

Magellan Behavioral Health Employee Assistance Program (EAP)

The EAP provides up to four counseling sessions free of charge. Services are easy to use and confidential. EAP counselors are professionals trained to assist employees with problems in a variety of areas, including alcohol and drug abuse, mental health, legal and financial difficulties, child and elder care, and family, grief and career-related issues. Contact Magellan Behavioral Health at **1-800-775-5138** for more information.

Anthem Better Prepared℠ Program

Your plan includes Anthem Better Prepared—a program designed to help you better understand and manage four chronic conditions: asthma, congestive heart failure, coronary artery disease, and diabetes. To register in this voluntary, confidential program, simply call our care management nurse consultants at **1-800-445-7922**. Enrolled members receive 24-hour access to registered nurses who can answer health questions, provide information about the most current treatment options and work with the member's physician to reinforce the prescribed plan of care. The goal of Anthem Better Prepared is to help members understand and better manage their health condition for improved quality of life.

Healthy Complements℠

Healthy Complements gives you access to a national network of acupuncturists, chiropractors, and massage therapists who offer Anthem plan members a 25% discount for services. You may also receive preferred pricing from a national network of health clubs and fitness centers. Purchase a variety of natural health and wellness products—from vitamins, minerals, and herbal supplements to videos and books—at discounted prices. Since Healthy Complements is a service, not a covered benefit, there are no claim forms involved. More information about Healthy Complements, administered by American Specialty Health Networks, is available at **www.anthem.com** under SpecialOffers@Anthem.

COVA CARE GLOSSARY

Allowable Charge – the amount on which deductible, copayment, and coinsurance amounts for covered services are calculated. It is the amount Anthem agrees to pay a provider for a service.

Coinsurance – the percentage of the allowable charge you pay for some covered services, such as laboratory, tests, shots, and x-rays.

Copayment – the fixed dollar amount you pay for some covered services, such as a physician visit.

Deductible – the fixed dollar amount you pay for covered services in a calendar year before the plan begins paying its share of covered services. Your annual deductible applies to diagnostic laboratory, tests, shots and x-rays and other covered services such as ambulance transport, private duty nursing and durable medical equipment. There is no deductible for wellness, preventive, dental, or drug benefits.

Emergency – the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity. This includes severe pain that, without immediate medical attention could reasonably be expected, by a prudent lay person who possesses an average knowledge of health and medicine, to result in:

- Serious jeopardy to the mental or physical health of the individual;
- Danger of serious impairment of the individual's body functions;
- Serious dysfunction of any of the individual's bodily organs; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Preferred Provider Organization (PPO) – a health benefit plan designed to give members incentives to use network health care providers. PPO plans can also be distinguished from HMO plans in that PPO members may see a specialist without a referral from a primary care physician. COVA Care is a PPO plan design.

Preventive care – coverage that includes an annual gynecological exam and prostate exam (age 40 and older) subject to copayment. It also provides coverage for a Pap test, mammography screening (one per year, age 35 and older), prostate specific antigen test (age 40 and older) and colorectal cancer screening (age 40 and older) subject to 10% coinsurance, with no deductible.

Primary care physician – a general or family practitioner, internist or pediatrician. You pay the primary care physician copayment for services from these providers.

Routine wellness care – coverage that includes an annual wellness check-up subject to copayment. It also covers routine laboratory, tests, shots and x-rays subject to 10% coinsurance, with no deductible. The plan pays 90% of the cost for these services up to $200 per member per year.

Specialist – any provider other than those defined as a primary care physician. You pay the specialist copayment for services from these providers.

Stay – the period from the admission to the date of discharge from a hospital or other inpatient facility. It is sometimes called a confinement. Hospital stays less than 90 days apart are considered the same stay and a new copayment is not required.

KAISER PERMANENTE — REGIONAL HMO

SERVICE AREA

Kaiser Permanente's service area includes the District of Columbia and the following cities and counties in Virginia and Maryland:

Virginia
Counties:
Arlington
Fairfax
Loudoun
Prince William

Cities:
Alexandria
Fairfax
Falls Church
Manassas
Manassas Park

Maryland
Counties:
Anne Arundel
Baltimore
Calvert (partial)
Carroll
Charles (partial)
Frederick (partial)
Harford
Howard
Montgomery
Prince Georges

Cities:
Baltimore

HOW THE PLAN WORKS

- Use your Directory of Providers to choose a convenient Kaiser Permanente medical center. Then select a primary care physician for yourself and for each enrolled family member.
- Your Kaiser Permanente physician provides or arranges all services.
- Specialty care is provided on a referral basis by a MAPMG physician.
- Members make appointments directly with the Kaiser Permanente medical center by calling:
  Metropolitan Washington, D.C.: **(703) 359-7878**
  Outside Washington Area: **1-800-777-7904**
- Outside the service area, coverage is available for emergency services and urgent care situations only, unless you are in another Kaiser Permanente service area.

You pay the total cost for care not provided by or arranged by your primary care physician with the exception of services for a life-threatening emergency, such as heart attacks, poisoning, or convulsions, and out-of-area urgent care.

APPROVAL OF CARE AT A GLANCE

- In an emergency, call 911.
- You have access to medical advice and assistance any time of day with a 24-hour medical advice line supported by registered nurses, physicians, and pharmacists.

SUMMARY OF BENEFITS — KAISER PERMANENTE

You must select a primary care physician (PCP) for care and to receive a referral to a specialist.

	Covered Services	You Pay
Outpatient Primary Care Physician (PCP) Visits	• Physician, x-ray, and other diagnostic services • Immunizations • Pre-admission testing • Voluntary family planning • Laboratory, pathology, radiology, and diagnostic testing	$10 $10 $10 $10 $0
Preventive Services	• Periodic checkups • Routine gynecological exam (Pap smear, pelvic exam, and breast exam — no referral needed) • Well baby care (children under 5)	$10 $10 $0
Specialty Care Physician Visits	Includes physician and outpatient facility services	$10
Outpatient Surgery	Free-standing ambulatory surgery center or hospital outpatient facility	$10
Inpatient Hospital Services *(For admissions arranged through your PCP and authorized by the HMO)*	• Includes semi-private room, intensive or coronary care unit (no maximum number of days) • Private room –if ordered by participating physician and approved by the HMO as medically necessary • Physician services • Surgery • Anesthesia • Diagnostic services such as lab and x-ray • Blood transfusion procedures, drugs • Physical therapy, chemotherapy, radiation therapy	$100 per admission
Maternity Care	• All routine outpatient pre- and postnatal care of the mother rendered by the OB/GYN • Diagnostic testing (such as ultrasounds and fetal monitor procedures) • Hospital care of mother and child	$0 $0 $100 per admission
Emergency Services For Life-Threatening Conditions *(Such as heart attacks, hemorrhaging, poisoning, loss of consciousness, or convulsions — no referral needed)*	• Hospital emergency room	$50 (waived if admitted) $10 for urgent care center
Mental Health And Substance Abuse Services *(You must contact the plan, and not your primary care physician, to coordinate care except in a life-threatening situation.)*	• Outpatient visits when medically necessary • Inpatient treatment when medically necessary • Detoxification	$10 $100 per admission $100 per admission
Complementary Alternative Medicine	• Includes chiropractic and acupuncture services when medically necessary (up to 20 visits)	$15

	Covered Services	You Pay
Family Planning And Infertility Services	• Sperm count • Hysterosalpinography • Endometrial biopsy	50% of allowable charge 50% of allowable charge 50% of allowable charge
	• Vasectomy (male sterilization) • IUD insertion • Oral contraceptives (subject to prescription drug copayments)*	$10 $10 $10
Therapy Services	• Physical therapy (up to 90 days per incident) • Chemotherapy and radiation therapy	$10 $10
Skilled Care	• Home health care, nursing, and other services in your home • Skilled nursing facility (up to 100 days maximum per member per calendar year)	$0 $100 per admission
Durable Medical Equipment	• Rental or purchase of plan approved durable medical equipment	$0
Prescription Drugs	Generic program (up to 60-day supply). Brand name drugs are covered only when a generic equivalent is not available, or when prescribed by a physician. ($15 surcharge applies to brand name drugs requested by the member and not required by the physician.)	$10 per prescription at a Kaiser Permanente on-site pharmacy
	When prescriptions are filled at a network pharmacy, your program covers the following: • Medically necessary drugs and medications prescribed by a participating physician • Any medication which requires a prescription	$20 per prescription at a participating community pharmacy
Mail Service Benefit	• Maintenance drug prescription (up to 90-day supply for medications prescribed for 6 months or more) filled through the mail service pharmacy	$8 per prescription
Dental Benefits	Plan pays an annual maximum of $1,000 per person for in-network services, and $500 for out-of-network services, with the exception of orthodontics. Plan pays a lifetime maximum of $1,000 per person for orthodontics.	
Annual deductible	• DHMO (in-network) • Out-of-network	$25 per person $50 per person
Diagnostic and preventive services	• DHMO • Out-of-network	0%* 25%*
Basic services	• DHMO • Out-of-network	20%* 40%*
Major services	• DHMO • Out-of-network	50%* 60%*
Orthodontics (age 19 and under)	• DHMO • Out-of-network	50%* Not covered
Vision Benefits	• Routine eye examinations and refractions	$10, waived for children under age 5
	• Discount on purchase of eyeglass lenses and eyeglass frames at a Kaiser Permanente Optical Shop only	75% of the cost of lenses and frames
	• Discount on the initial examination, fitting, purchase, and follow-up examinations for contact lenses at a Kaiser Permanente Optical Shop only	85% of the cost of contact lenses

**Based on dental fee schedule. See Member Handbook for details.*

	Covered Services	You Pay
Out-Of-Area Urgent Care *(For unexpected conditions requiring immediate attention such as high fever, vomiting, or sprains — no referral needed)*	• Physician's office visit • Kaiser Permanente urgent care center/after hours care center	$10 $10
Additional Information	• Lifetime maximum • Annual deductibles • Benefits administered • Annual maximum out-of-pocket expense (does not include copayments for prescription drugs or dental benefits)	None None Per contract year Two times the total annual premium

SPECIAL PROGRAMS

Employee Assistance Program (EAP) Magellan Behavioral Health

Through the EAP, you can receive assistance for a wide range of issues including:

- Parenting concerns
- Family and relationship issues
- Alcohol and drug abuse
- Emotional difficulties
- Stress-related problems
- Conflicts at home and work
- Other personal concerns

The EAP provides problem identification, counseling and referral services for up to four visits at no cost to you. Call Magellan Behavioral Health toll-free at **1-877-347-0140** for assistance.

Discounted And Alternative Medicine Services

Kaiser Permanente offers discounted complementary and alternative medicine and other services to its members, including:

- Chiropractic, acupuncture, and massage therapy
- Discounts at area health clubs
- Discounts on health and nutrition products
- Discounts on LASIK (laser vision) surgery

Wellness Programs

Preventive medicine and health promotion are a basic part of your care at Kaiser Permanente. Some of the ways we provide preventive care are:

- Be Well! Classes. Examples have included Alternative and Complementary Medicine, Avoiding Back Pain/Neck Pain, Managing Menopause, and more.
- Healthphone is a series of pre-recorded health messages on over 130 topics available 24 hours a day, every day, by telephone.
- The Healthwise Handbook® is a guide to effective home treatments of over 180 common health conditions.

Virginia Department of
HUMAN RESOURCE MANAGEMENT